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Special Article

Medical Education in the United States: Some Current Problems and an Uncertain Future

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My purpose is to identify several issues of critical importance to medical education and to medical practice which really are inseparable aspects of our profession. Each issue encompasses specific problems; for some I will offer possible solutions and responses. Our success in addressing these issues may determine the future of our profession. These are:

- medical manpower,
- the finite number of available positions in accredited training programs,
- the setting of standards (which we do uniquely),
- scientific and technologic advancements,
- paying for the cost of medical education,
- the corporate structure of medicine,
- the public's perception of our profession.

In our world of modern medicine, the changes taking place are massive, and the rate of change is awesome. But most physicians in the United States have not yet appreciated these facts. They are busy with their practices, and changes external to that practice are not as interesting to them as their daily work. Within the changing world of medicine, there are two hard and unchanging facts, both of which concern education: 1) in order to obtain a medical license in this country, all but two states require at least one year of graduate medical education; 2) to obtain admission to a hospital staff and to practice a medical specialty, many more years of graduate education are needed.

Opportunities for Graduate Medical Training

Until recently, hospitals in this country provided abundant numbers of accredited positions for graduate medical education — more than the number of senior students in our own medical schools in this country and more than the number of foreign medical graduates who wished to obtain graduate medical education in the United States. Now all this has changed. Foreign medical graduates continue to seek U.S. training opportunities in ever-increasing numbers. In the last fifteen years, U.S. medical schools increased the size of their classes, and new schools appeared; as a result, the number of graduates has doubled. Moreover, the size of future graduating classes of U.S. schools is expected to continue to increase over the next few years so that nearly 17,000 medical students will graduate in 1986 (Table I). These graduates, as well as unknown numbers of foreign medical graduates, will be seeking positions in graduate medical education programs.

For several years, the number of applicants has already exceeded the number of offered positions, and this disproportion is likely to become even more exaggerated in the years immediately ahead. The major program that matches students with positions, the National Resident Matching Program (NRMP), does not include all available positions in graduate medical education. Another independent program offers a match for several of the surgical subspecialties and for neurology. Furthermore, 800 to 900 positions in hospitals of the armed forces are not included in the NRMP program. In fact, only 40% of the general surgical positions are included in the match. Yet in the NRMP in 1981 we had nearly 19,000 applicants; now, in 1984, the number is over 28,000, the highest ever recorded (Table II).

At the same time, the number of U.S. citizen graduates of foreign medical schools who are seeking positions has jumped enormously in the last two years (by about 70%); they now number about 3,000. Applications from alien foreign medical graduates have increased to over 7,000. The total of foreign medical graudates is approximately 10,000 individuals.

An interesting aspect of the match in March 1984 is that the majority of some 7,000 alien foreign medical graduates gave return addresses within the United States. These individuals are not applying from foreign countries. They are here already, probably working in some capacity within our health care delivery system. Another

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TABLE I

Graduates of U.S. Medical Schools, Actual and Estimated*

1983	15,728
1984	16,558
1985	15,839
1986	16,928
1987	16,859

*Source: American Association of Medical Colleges, 1983.

TABLE II

Results of the 1984 National Resident Matching Program*

	Total Applicants	Active Applicants	Percent Matched
U.S. Med Grads	16,130	14,741	92
Fifth Pathway	425	339	78
Canadian	188	91	81
Osteopathic	414	206	62
U.S. MDs	1,427	768	50
U.S. Foreign Med Grads	2,922	1,695	44
Alien Foreign Med Grads	7,143	4,212	22
Total	28,649	22,052	73

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interesting aspect of this group is that although the median date of graduation from medical schools is 1980, some graduated in the 1960s, and many have been in the match before. Only 30% have graduated after 1982. Only 22% of alien foreign medical graduates were successful in the match this year.

The present issue of the foreign medical graduate in the United States originated immediately after World War II, with the universal perception that the number of physicians in our nation available to care for the health needs of our population was inadequate. Accordingly, the Congress made it possible, by passing favorable immigration laws, for foreign trained physicians to enter the United States. They came by the thousands and have been valued additions to the medical community. In fact, during the 1960s and 70s, the number of foreign medical graduates receiving licenses nearly equalled the number of those who graduated from our own schools, since many who came to the United States to obtain graduate medical education elected not to return to their home countries but to stay and practice in this nation.

Setting Standards for Graduate Medical Education

The influx of foreign medical graduates began to drop when the Congress perceived that there was no longer a need to augment the number of graduates from our own schools. In 1976, the immigration laws were changed to require a different kind of a cognitive examination, the Visa Qualifying Examination. The greater difficulty of this examination caused a decline in interest among foreign medical graduates in coming to the United States. In the present decade, however, there has again been a marked increase in applications from alien foreign medical graduates, augmented by those of U.S. citizens who have graduated from foreign medical schools.

The goals of the foreign medical graduates have also changed in the last decade. When the programs were first started, the aim was to offer our country's advanced technology and excellent educational programs in medicine to individuals from other countries who could not obtain such experiences in their native lands. It was hoped they would return to their home countries to apply the results of the superior education they had gained here. But many of them stayed here, some having come to our country for that purpose. A decade ago, thousands of physicians came annually with a special J-visa solely to obtain graduate medical education and then return to their home countries. At present, this number has dropped to less than a few thousand. Yet the total number of foreign medical graduates in our training programs has not changed materially. The difference in the figures accounts for the many foreign medical graduates who come to the United States on immigration visas in order to stay in our country to practice medicine.

One unsolved problem in this regard is how our graduate educational system can fulfill the needs of individuals who are already well trained but need some special qualification or experience before they can return to practice a special aspect of medicine in their own country. At the moment, all foreign medical graduates are treated in the same way; all are required to pass the same kind of examination, but the examination may be inappropriate for the more advanced foreign medical graduates.

Why is it important to examine the qualifications of the foreign medical graduate in a special way? A review of the performances of foreign medical graduates on the specialty certifying examination for internal medicine as

compared to graduates of the U.S. and Canadian schools (1) indicates that the critical factor is where students had their medical school training (Table III). Foreign medical graduates have a decided disadvantage when their performance is compared to that of graduates of our own schools.

TABLE III
Certification by American Board of Internal Medicine

	Percent Certified		
	1980	1981	1982
Graduates of U.S./Canadian Schools	84	84	84
All	58	58	57
Foreign Medical Graduates	29	26	25

In our country the private sector of medicine, not the government, controls graduate and undergraduate medical education. We as professionals are responsible, and we are accountable. To provide highly skilled practitioners of medicine for the American public from our educational programs, we have to be aware of the qualifications of all individuals who graduate from our programs.

The proprietary medical schools that have arisen in the Caribbean Islands in the last ten years present another critical problem. Perhaps 10,000-15,000 or more U.S. citizens began their educational experience in these medical schools. Not only is the basic science experience offered by these schools inadequate when compared to schools accredited in our own country and Canada, but these schools cannot provide clinical clerkships for their students. Many students are personally responsible for finding opportunities for clinical clerkships, which are usually in this country and in community hospitals that have no educational program of any sort nor any tradition of education. There is no standard curriculum, no certainty of adequate supervision, no acceptable criteria for assessing the accomplishments of these students. With such experience these undergraduate students are awarded an MD degree and, as expected, they are very anxious to obtain a position in a graduate medical education program in the United States. Without graduate education experience in an accredited program, which is a requisite for licensure, the MD degree is essentially useless.

How can we be fair and equitable to all groups? Accrediting bodies exist in the private sector for accrediting our own schools and the graduate programs. The Liaison Committee on Medical Education, first organized in the 1940s and composed of representatives of the American Medical Association (AMA) and of the American Association of Medical Colleges (AAMC), is responsible for ensuring that schools in the United States and Canada adhere to agreed-upon standards. The Committee's authority comes from the federal Office of Education. It is the only component of medical education in the United States that has official federal sanction, but this authority does not extend to the Caribbean Islands. Efforts by the Federation of State Medical Boards to apply the Liaison Committee's criteria to the Caribbean schools have so far failed.

In graduate medical education, the group that addresses the entire field is called the Accreditation Council for Graduate Medical Education (ACGME). It includes the American Board of Medical Specialties, the American Hospital Association, the AMA, the AAMC, and the Council of Medical Specialty Societies (which represents 22 specialty societies), as well as representatives from the resident community, the federal government, and the public. The ACGME is responsible for applying accreditation standards to all the training programs in the country, about 4,000-5,000 within the United States in various disciplines. Approximately 74,000 graduate students are enrolled in those programs at the present time.

As one effort to address the issue of the foreign medical graduate, and particularly the U.S. citizen foreign medical graduate, the ACGME will initiate a new kind of cognitive examination in July of this year, the Foreign Graduate Examination in the Medical Sciences (FGEMS). This examination will be comparable to the examinations of the National Board of Medical Examiners, Parts I and II, which are taken by most of the students in our country's medical schools. For the first time, we will have a comparable examination for all individuals entering graduate medical education — our own students from our own schools, the alien foreign medical graduates, and the U.S. citizen foreign medical graduates. Until now, the last group has been allowed to take a shorter examination, one considered by many educators to be easier than the NBME examations.

But there remains the problem of how to assess fairly the clinical competence of individuals coming from foreign schools. No one yet has found an appropriate solution. A student may be able to memorize all the material in a textbook and pass a cognitive examination. However, when that same individual is faced with the need to relate to a human patient, other and different skills are needed in order to extract the essentials of a history and do a careful, accurate physical examination.

Tests for those skills should be required of all who enter graduate medical education, whether they are from U.S. schools or from schools in other countries. From

our own schools we now rely upon the faculties to attest to the competence of our graduates, a practice which has recently been criticized. Some feel that the unstructured fourth year of most medical schools does not allow sufficient time in the "old-fashioned" clinical clerkships, which provide students with the opportunity to develop some proficiency in clinical skills. Some individuals from our own schools who enter residency programs have to be taught how to perform an accurate history and physical examination.

Opportunities for Medical Practice

Manpower problems encompass more than just the demand for graduate medical education. There probably are too many physicians in the United States, already as many in 1984 as were predicted by the GMENAC study for late in this decade (2). Many physicians throughout the country report that their communities now have enough or even too many physicians. In almost every discipline except physical medicine and rehabilitation, some branches of pediatrics, psychiatry, and preventive medicine, residents and trainees find it increasingly difficult to locate a practice opportunity.

The maldistribution of specialties in communities throughout the nation seems largely to have been solved. Subspecialists now practice even in small communities of 10,000-20,000 people (1) and are readily accessible to most patients. At the same time, medical schools will continue to graduate more and more physicians every year and will continue to do so for at least the next several years.

The question is how to halt this surplus of physicians. The certifying boards and the residency review committees do not believe it is their job to regulate manpower. Their mission is to provide acceptable standards for evaluating the capabilities of individuals or of training programs. The solution may not be forthcoming until medical schools are forced to reduce the size of their entering classes for economic reasons, although it will be some time before the effect of that reduction will be felt. Nevertheless, there will be fewer positions in American medical schools in a few years. Perhaps the desire to enter medical school will also begin to decline, particularly as student guidance counselors become aware of the difficulty of physicians trying to obtain positions in graduate medical education and later in practice.

Another consequence of the medical manpower surplus is growing tension between older and younger physicians in practice. Physicians already on hospital staffs may resist providing opportunities for young physicians who compete with them. Some doctors completing graduate medical education programs join health maintenance organizations and preferred provider organizations, often because no other practice position is available when they are ready to start practicing. It is predicted that in the future some physicians will never practice in a hospital and will do only outpatient work, like some of the family or general practitioners in the British national health system. Some may perform only administrative work and never have an opportunity to care for patients.

Sites of practice are already changing. Throughout the country, satellite centers like those in the Henry Ford Hospital system, emergency centers, drop-in care centers, and ambulatory surgical centers are rapidly growing. An acute care hospital derives an average of 40% of its income from surgery. If the hospital does not own the outpatient surgical facility, competition may become very severe. Some hospitals may close or have to alter their major missions and become facilities for long-term care. It is predicted that with the diagnostic-related groups (DRG), with the manpower surplus, and with the advent of new kinds of outpatient facilities, as many as 1,000 of our hospitals will close.

These changes all relate to the problem of available positions for graduate medical education, for the basic residency, and for further fellowship training. Some graduate education must take place in these outpatient facilities.

Paying the Cost of Graduate Medical Education

At the moment 74,000 individuals are in graduate training. The costs are significant. For example, if we assume an average stipend of $22,000 (the mean paid by hospitals belonging to the Council of Teaching Hospitals), the cost per year just for stipends is $1.5 billion. At the same time, indirect costs are rising, and third-party payors are increasingly reluctant to support education at any level. A dramatic example is the 1983 report of the Bowen Commission on the Medicare Hospital Trust Fund, which is near bankruptcy and predicted to be billions of dollars in debt by the early 1990s. One of the Bowen Commission's recommendations is that the Medicare Hospital Trust Fund should no longer support medical education, nursing education, or paramedical education. However, the Commission added the warning that withdrawal of funding for medical education should not occur until Congress has identified alternate sources of support. However, Congress is so concerned about being able to pay for the hospital care of the elderly that it may conceivably withdraw support of graduate medical education before alternate sources of funding have been identified.

At present, about 30% of the direct cost of graduate medical education and a greater percentage of the indirect costs comes from Medicare funding sources. Traditionally, graduate medical education has been supported by patient care revenues, based on the philosophy that a portion of the cost of a patient's care should support medical education. Today, an average of 83% of a resident's stipend and 62.5% of a clinical fellow's stipend is obtained from patient revenues. This figure is lower for state institutions and higher in private institutions like Henry Ford Hospital or the Mayo Clinic.

This crisis is intensified because business coalitions, as well as the government, are objecting to paying not only some of the cost of medical education but also the cost of research and the development of new technology. If these third parties negotiate contracts with hospitals to provide payment only for services directly received by patients, then where will the support come for medical education, for research, and for new technology? These problems and issues are exacerbated by the escalating cost of medical care.

Suggestions are being made that the resident stipend should be reduced or even that residents should pay tuition. However, we should not forget that hospitals receive an enormous amount of service from members of the house staff who make an essential contribution to the care of the patients served by the hospital. Probably a tradeoff will take place. Individual hospitals will reassess whether service from the house staff balances the cost of education. Some hospitals may elect to stop offering graduate medical education; others will continue. I cannot predict the impact this will have on the number of available positions for training.

A significant aspect of the Prospective Pricing System using the DRGs is that for the first time the cost of education has been identified and distinguished from the cost of patient care. As a result, the cost of graduate medical education is vulnerable as it never has been before. Very likely, there will be less support for medical education from all sources in the future.

At the same time, some tertiary care hospitals are having trouble attracting the patients needed to validate their programs in service, in education, and in research. Large centers often have established contracts with affiliated hospitals to accept some residents and fellows for education in those disciplines. But tertiary care centers may now view some affiliated hospitals as a source of competition for clinical material, and, as a result, some affiliations will be dropped. Fewer residents and fellows will be sent from the parent institution to the affiliated hospital, which accordingly will have increased difficulty competing with the teaching hospital at the tertiary care level. In this way, teaching hospitals may survive, or at least protect their teaching programs, but the number of available opportunities for education will be reduced.

Nor can we look to much support from the new breed of hospital administrators. In the past, hospital administrators shared the view that graduate programs in education were of great value to the hospital because they were attractive to physicians who brought in patients and increased the hospital's prestige. Whenever an accreditation decision went against one of the programs of such a hospital, the hospital administrator was usually prompt to marshall the resources needed to have the program reinstated. However, the present generation of administrators, who are trained in business and economics, must find ways to diversify hospital activities in order to bring in more income. Although they look for all kinds of opportunities, almost none of them have anything to do with education. This attitude of many hospital administrators will contribute to the lessened will of American hospitals to continue to support positions in graduate medical education.

Accreditation of Graduate Medical Education Programs

How does the hospital start a graduate medical education program? It must apply and be accredited. To increase or to decrease the number of available positions requires approval by the appropriate agency. In the private sector of medicine, the ACGME is the agency responsible for establishing and maintaining acceptable standards in graduate medical education. This group supervises all the residency review committees (RRC), each of which is composed of representatives of the specialty board and representatives of the AMA Council of Medical Education. In many but not all committees, a specialty society also contributes. The RRC proposes the standards against which programs are to be judged; these standards reflect the views of representatives from the specialty board responsible for certifying graduates of the program, from the AMA Council of Medical Education, which has a traditional interest in graduate medical education, and often from the specialty society. This organization is now being challenged by elements of our society who believe its structure violates antitrust laws.

Some lawyers feel that the medical profession is guilty of antitrust violations in the control of graduate medical education (3). They propose that current rules and standards be relaxed to allow many other individuals to enter American hospitals and provide different forms of medical care not legally permitted at present. The legal challenge is based upon the concept that medicine is no different from any other business: that doctors are like any other group engaged in commerce in our country and are subject to the same forces of the marketplace.

Most of us feel quite differently about that. In the next few years there will be a considerable debate as to whether the standards developed by the private sector of medicine will stand the test of scrutiny, probably in the law courts, but certainly in the court of public opinion.

Coping with These Stresses

The most successful way to address all of these issues is to adopt the model provided by some teaching hospitals, as exemplified by Henry Ford Hospital, the Mayo Clinic, or the Cleveland Clinic. Whenever we make the welfare of the patient our primary goal, we create a favorable environment for education, research, and the development of new technology.

There is no question that those who look first to the welfare and needs of the patient will receive the most public support. At medical schools, the essential mission is to teach students, either undergraduates or graduates, and the patient's welfare, however safeguarded, is not the primary goal.

Another pressure on medical practice and education is the growing interest of the "for-profit" hospital chains in buying or managing hospitals. Until now these groups have not been much involved with graduate medical education, for they are mostly concerned with small hospitals, usually in the sunbelt. However, they are becoming involved with the larger hospitals. For example, the University of Louisville's teaching hospital has been purchased and is now managed by Humana, while George Washington University Hospital in Washington, DC may be either sold or managed by a for-profit chain.

The danger for the future of graduate medical education when for-profit chains take over large teaching hospitals is that their primary goal is to make money for the stockholders. This is a relatively new concept for us. In this country the traditional hospital has been conceived as an institution of public service, willingly supported by the community, where the indigent receive care, and to whose appeals for funds the public will respond. The hospital is seen as a place where the public volunteer their services. People in the community support their hospital because they perceive it as an instrument of social good. If that hospital is purchased by a for-profit chain, the attitude of the public may change, and with it may change the attitude toward all aspects of the medical profession.

A recent article (4) describes how the public's perception of the medical profession has already changed in the last three-and-a-half decades. We have become much better off financially, individually, and collectively, but we have fallen greatly in society's perception of us both as individuals and as a profession. Just as the attitude of the public will change if a for-profit chain buys a community hospital, in the same way the attitude is changing about the professions of medicine, nursing, and even paramedical vocations. This change in attitude accounts for much of the public's willingness to explore different forms of medical care. Acupuncturists are able to do more now than they ever did before. The public allows experiments in health care delivery by podiatrists, chiropractors, and others. That attitude probably reflects a dissatisfaction with our own performance during the last thirty or forty years. Too absorbed by our own technology and its advances, we are perceived by society as much more materialistic than ever before, less willing to share, to give, to take care of people when they need us. That is a warning we must heed, because society grants us our privileges, and that same society can take those privileges away.

Questions and Answers

Dr. Fred Whitehouse*: I was delighted to hear your comments that we should be scientists and healers more than businessmen. Would it be of value to withdraw from the political arena and become more monastic, as it were? Would we be further ahead? The philosophy of the politically-minded physician in organized medicine is opposed to that. The American College of Physicians historically took that position, and it actually resulted in the American Society of Internal Medicine coming to the forefront. Have we gone too far in our political involvement in trying to protect our own interests?

Dr. Reitemeier: I think we've simply gone about it in the wrong way. It isn't that we're out of place in the Halls of Congress or the State Legislature. I have now been in contact with enough representatives at various levels of government to be absolutely convinced that physicians have an enormous, constructive contribution to make. We must not be self-serving, but provide a resource to explain to legislators who have to make rules and regulations about these costs, what we do, what our standards are. Legislators need our help. They are interested in medicine. They want the public to be well-served in the health care field, and they know that physicians have to be critically involved. We can help them if we wish.

I am quite proud of the way the American College of Physicians has gone about its business of relating to the federal and some of the state establishments because they have tried to offer constructive suggestions, to be a

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source of information, and to look at medical policy issues, not focus on remuneration.

Dr. Michael Kleerekoper*: You talked about the excellent service our house staff provides. What about the competition from the nonphysician practitioners who also render excellent service for us?

Dr. Reitemeier: This is going to be a real problem. It is predicted that in the next 25 years the influence of physicians in this country will decrease, and the influence of the nursing profession will increase, as will that of the allied health professionals. As I said, society is experimenting with different ways in which health care can be delivered. This trend will continue for some time. Our best course is to continually strive to provide the highest quality medical care.

Dr. Clarence Livingood*: Could you tell us a little more about your talks with members of the Congress.

Dr. Reitemeier: At an assembly of the Presidents and Presidents-elect of many of the largest medical societies in our country in January 1984, Senator Howard Baker from Tennessee, the Majority Leader in the Senate, said candidly that no major medical legislation will be passed by the Congress in 1984. But he also warned that no matter who wins the coming election, the facts of the escalating costs of medical care are so clear-cut that Congress will be very receptive to proposals to reduce those costs. He encouraged us as physicians to come to the committees in Congress and present constructive plans for reducing costs. He also encouraged us to get to know the staff of the committees, because they would have to understand the basis of any proposals we might suggest.

A Democratic representative from Massachusetts pointed out that Congress has no plan for rescuing the Medicare Hospital Trust Fund or for controlling the overall cost of health care to the federal government. Congress is eager to find workable solutions, but the medical profession has not offered any kind of proposal. We all know there is waste in our system, that we could reduce costs if we really tried. Not only is this true in the teaching centers, but it is also true in community hospitals.

I don't have an overall plan either, other than for all of us to be as responsible as we can. We should not admit patients who do not need hospital services. If we all were to do that, and if that meant empty wards in some of our hospitals, then those wards could be closed, and some personnel (painfully) would be let go. Clinical laboratories could reduce their personnel and their space also, as could radiology laboratories; and that would bring down the cost of hospital care. Nothing less will do it. Costs are not reduced if we keep the plant going and retain all of the personnel.

As a profession, we have not addressed the common problem of escalating health care costs, which frightens Congress and for which it has no solution. Since there is no plan, Congress will act reflexively with a knee-jerk reaction. There will be more regulations. The DRGs will be squeezed down even more. There may be increased copayments. Congress will have no choice but to take some action. Most of us in the medical profession have not really addressed the magnitude of this problem.

DRGs, even if wildly successful from the standpoint of the government, would never solve the problem of the anticipated deficit in the Hospital Trust Fund for Medicare. Congress has set itself a goal of a $4.1 billion reduction in Medicare by 1986. That's only two years away, and not much has been done so far this year. So just imagine what is going to happen in 1985 and 1986. The reductions in costs will be forced and drastic.

Dr. William Beierwaltes*: Could you elaborate on the ramifications of the supposed takeover by for-profit teaching hospitals? How will this affect not only postgraduate education, but the traditional medical school, and also the research, both clinical and basic, associated with many of these teaching hospitals?

Dr. Reitemeier: It scares me to think of what could happen. When a for-profit organization takes over a teaching center, and the new primary goal of the teaching center is to make a profit, any cost factor such as education, research, and new technology may be much less well off than now. Unless the medical school or teaching facility is clever enough to find alternative sources of funding, there may be no support for these activities. At present, the practice plans of the faculties are filling the gap in some centers, but these plans are also taking so much of the time of the individuals in the teaching centers that they have less energy and time to devote to education and research. Yet, we probably are on the brink of another massive advance in our knowledge and technology, and we will need that system of investigators, graduate students, and the time and freedom they need to realize the potential of these advances.

At present, 50% of the money awarded by the National Institutes of Health for medical centers goes to the top twenty schools; 25% more goes to the next twenty. So the top forty schools get 75% of the research funding, while the bottom eighty get the rest. That's the group likely to lose the most in the future. Students who train at medical centers that have little basic research will not learn an important part of medicine: clinical investigation and basic research. The quality of that student's

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education will suffer. And that could be made still worse if the for-profit chains take over the teaching centers.

Dr. Jay Gorell*:
Who will provide the leadership to articulate the concerns of the medical profession to the Congress? I shudder to think of reposing my faith in the AMA.

Dr. Reitemeier: I wish I could tell you. I don't know of anyone or any group. The Council of Medical Specialties Societies has a theoretical membership of 275,000 practicing physicians, every one of whom is a specialist. That group acting in concert would be a counterpoint to the AMA, but the individual societies will never surrender their autonomy to allow that organization to speak for them with a single voice. The AMA can do so because it is an oligarchy.

One of the "penalties" of living in a democracy like ours is that there is no single voice to speak for us. Notice what happened in France. Mr. Mitterand, the head of that socialist government, decided that there were too many medical students in the schools in France, and two years ago he simply lopped off a quarter of the entering freshman class. The next year he decided that only three-fourths of the juniors should be allowed to go into the senior year. Such a form of government can write legislation like that, or make such a declaration, and it can be enforced. The result was riots in the street of Paris led by medical students, but the declaration remained in force. We've got a democratic form of government. We've got freedom, but we do not have a unified profession. The private sector of medicine does not speak with one voice to Congress.

Dr. Paul D. Sweda*: Do you have data to support the assumption that the graduates of those top forty medical schools are better doctors than those who graduated from the other eighty?

Dr. Reitemeier: Absolutely none.

Dr. Sweda: So the premise may not be valid. We're talking about producing good physicians for the community in regard to research and clinical training. It would be nice to be able to show that since all that research goes on around them, they practice better medicine as a consequence.

Dr. Reitemeier: I don't have any data. But I think a reasonable assumption is that one attribute of a good physician is the ability to critically evaluate the literature, to look at any kind of data critically. It is in an environment containing research activities that the student acquires those habits.

Dr. Sweda: Part of the high cost of medical education or the indirect costs may derive from the fact that when you are less sure of yourself you tend to perform more tests. We produce physicians who are outstanding at writing tests, but we have lost the training in clinical skills. We get more technology, we have more tests. It does not necessarily mean the patient gets better care. It does mean that the patient gets more expensive care. If we produce clinically skilled professionals, we might recoup a greater percentage of that and still be better off as physicians. And the community would probably be a lot better off because they would have better trained clinicians.

Dr. Reitemeier: I don't disagree at all. In the teaching centers it is likely that to increase the efficiency and to minimize the length of stay, the attending physician will become much more involved in patient care, making decisions about how much of the resources will be used, rather than leaving it totally to the house staff. The example set may be a needed model for students at all levels.

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References

1. Schwartz WB, Newhouse JP, Bennett BW, Williams AP. The changing geographic distribution of board-certified physicians. N Engl J Med, 1980;18:1032-8.
2. Bowman M, Katzoff JM, Garrison LP Jr, Wills J. Estimates of physician requirements of 1990 for the specialties of neurology, anesthesiology, nuclear medicine, pathology, physical medicine and rehabilitation, and radiology. A further application of the GMENAC methodology. JAMA 1983;250:2623-7.
3. Havighurst CC. The doctors' trust: Self-regulation and the law. Health Affairs 2;1983:64-76.
4. Ginzberg E. The monetarization of medical care. N Engl J Med 1984;310:1162-5.